No. 76-188

In the Supreme Court of the United States

OCTOBER TERM, 1976

ERVING B. GOURLEY, DIRECTOR OF THE DIVISION OF FAMILY SERVICES OF THE STATE OF MISSOURI, ET AL.,
PETITIONERS

v.

HARIECE LEWIS, ET AL.

ON PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE EIGHTH CIRCUIT

MEMORANDUM FOR THE UNITED STATES AS AMICUS CURIAE

DANIEL M. FRIEDMAN,
Acting Solicitor General,
Department of Justice,
Washington, D.C. 20530.

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MEMORANDUM FOR THE UNITED STATES AS AMICUS CURIAE

This submission is made in response to the Court's invitation to the Solicitor General to express the views of the United States.

QUESTION PRESENTED

The United States will address the following question: Whether a state that participates in the medicaid program is required to provide federally assisted medical aid to supplemental security income recipients to whom it would have been required to provide exclusively state-financed medical aid had its 1972 medicaid plan remained in effect.

STATUTORY PROVISIONS INVOLVED

Section 1902 of the Social Security Act, as added, 79 Stat. 334, and amended, 42 U.S.C. (Supp. V) 1396a, provides in pertinent part:

(a) A State plan for medical assistance must—

* * * * *

(10) provide—

(A) for making medical assistance available all individuals receiving aid or assistance under any plan of the State approved under title I, X, XIV, or XVI, or part A of title IV of this Act, or with respect to whom supplemental security income benefits are being paid under title XVI of this Act;

* * * and

(C) if medical assistance is included for any group of individuals who are not described in clause (A) and who do not meet the income and resources requirements of the appropriate State plan, or the supplemental security income program under title XVI of this Act, as the case may be, as determined in accordance with standards prescribed by the Secretary—

(i) for making medical assistance available to all individuals who would, except for income and resources, be eligible for aid or assistance under any such State plan or to have paid with respect to them supplemental security income benefits under title XVI of this Act, and who have insufficient (as determined in accordance with comparable standards) income and resources to meet the costs of necessary medical and remedial care and services * * *.

* * * * *

(f) Nothwithstanding any other provision of this title, * * * no State * * * shall be required to provide medical assistance to any aged, blind, or disabled individual (within the meaning of title XVI of this Act) for any month unless such State would be (or would have been) required to provide medical assistance to such individual for such month had its plan for medical assistance approved under this title and in effect on January 1, 1972, been in effect in such month * * *.

STATEMENT

1. Title XIX of the Social Security Act, as added, 79 Stat. 343, and amended, 42 U.S.C. (and Supp. V) 1396 *et seq.*, creates a cooperative federal-state program, commonly called "medicaid," for the payment of the medical expenses of certain categories of needy individuals. In order to participate in the medicaid program, a state must establish a medicaid plan and submit it to the Secretary of Health, Education, and Welfare for approval.

a. Prior to 1974, to be approved a state medicaid plan was required, at a minimum, to cover "individuals receiving aid or assistance under State plans approved under titles I, X, XIV, and XVI of this Act [relating to old-age assistance, aid to the blind, aid to the permanently and totally disabled, and aid to the aged, blind, or disabled], and part A of title IV of this Act [relating to aid to families with dependent children]." Section 1902(a)(10) of the Act, 42 U.S.C. (1970 ed.) 1396a(a)(10). These individuals are generally referred to as the "categorically needy." In addition, the state plan, at the state's option, also could cover individuals who satisfied the physical requisites (*e.g.*, age, blindness, or disability) but not the means test for categorical assistance, but whose income and resources nevertheless were insufficient to meet the costs of necessary medical or remedial care or services.

Sections 1902(a)(10) and 1905(a) of the Act, 42 U.S.C. (1970 ed.) 1396a(a)(10) and 1396d(a). These individuals are generally referred to as the "medically needy."

Once a state's plan was approved by the Secretary, the federal government paid to the state a specified percentage of the medical expenses that had been paid by the state on behalf of the categorically needy and, if covered by the plan, the medically needy. Section 1903(a) of the Act, 42 U.S.C. (1970 ed.) 1396b(a). Although a state's plan might also have covered individuals who were neither categorically nor medically needy, the federal government did not reimburse the states for payments made to such individuals. *Ibid.*

b. In 1974, the statutory structure of federal-state assistance to the categorically needy was significantly amended. Titles I, X, and XIV of the Social Security Act were repealed (except with respect to Puerto Rico, Guam, and the Virgin Islands). See Section 303 of Pub. L. 92-603, 86 Stat. 1484. To replace the programs that had existed under those Titles, Title XVI was amended to establish a program of supplemental security income for the aged, blind, and disabled. Title XVI of the Act, 86 Stat. 1465, 42 U.S.C. (Supp. V) 1381 *et seq.*

To reflect this change, Congress also amended Section 1902(a)(10) of the Act to require states participating in the Title XIX medicaid program to furnish medical assistance "to all individuals * * * with respect to whom supplemental security income benefits are being paid under title XVI."[1] Congress also recognized, however, that more

[1]Since the program of aid to families with dependent children (Title IV-A) had not been affected by the new amendments, and the categorical assistance programs under Titles I, X, and XIV, and old Title XVI, had not been repealed or amended with respect to certain territories, Section 1902(a)(10) retains the requirement that medical aid be furnished to individuals receiving assistance under those programs.

individuals would be eligible under the supplemental security income program than had been eligible under the superseded categorical assistance programs, *i.e.*, that the new legislation had resulted in an expansion of the class of individuals considered to be categorically needy, and that it might be financially burdensome to the states to be forced similarly to expand medicaid coverage. See S. Rep. No. 93-553, 93d Cong., 1st Sess. 56 (1973). Congress therefore added Section 1902(f) of the Act, providing that "[n]otwithstanding any other provision of this title, * * * no State * * * shall be required to provide medical assistance to any aged, blind, or disabled individual (within the meaning of title XVI * * *) * * * unless such State * * * would have been * * * required to provide medical assistance to such individual for such month had its plan for medical assistance approved under this title and in effect on January 1, 1972, been in effect * * * ." 42 U.S.C. (Supp. V) 1396a(f).

In pertinent part, the medicaid program otherwise remained as it had been before 1974.

2. In 1972, the medicaid plan of the State of Missouri covered the categorically needy, as it was required to do as a condition of approval, and the federal government paid a portion of the costs incurred by the State in providing medical aid to those individuals.[2] The State's plan did not cover the medically needy but the State did provide medical aid to individuals, other than the categorically needy, who received welfare assistance under the State's own general relief program (Add. Stip. 2). Although the latter coverage

[2]The State at that time participated in the categorical assistance programs of Titles I, IV-A, X, and XIV; it did not participate in the old Title XVI program (Add. Stip. 2). "Stip." and "Add. Stip." refer to the stipulation and additional stipulation of facts filed by the parties in the district court.

was provided under the state plan approved by the Secretary, the federal government did not reimburse the State for its medical payments to or on behalf of those individuals (Add. Stip. 2), because such coverage was outside the scope of Title XIX. The State was entitled, however, to federal reimbursement of 50 percent of the plan's administrative expenses, including the expenses of administering the exclusively state-financed portion of the plan's coverage. See Section 1903(a)(3) of the Act, 42 U.S.C. (1970 ed.) 1396b(a)(3).

The State amended the federally assisted portion of its plan in 1974 following the amendments to the federal statute. Pursuant to Section 1902(f), the State determined not to extend medicaid coverage to individuals eligible for supplemental security income benefits who would not have been eligible for benefits under the superseded categorical assistance programs (Stip. 4; Add. Stip. 2). The Secretary approved the new plan (Add. Stip. 1-2).

3. Respondent Lewis receives supplemental security income but would not have been eligible for benefits under the superseded categorical assistance programs (Stip. 4). She therefore is not eligible for federally funded medical assistance under the State's amended plan (*ibid.*).

Nor is respondent eligible for medical aid under the state-financed portion of the State's plan. That portion of the plan provides medical aid only to individuals receiving welfare assistance under the State's general relief program, and because respondent now receives supplemental security income she no longer is eligible, as she would have been in 1972, to receive state welfare assistance (Pet. App. A3). Accordingly, when respondent applied to the State for medical aid, her application was denied.

Respondent then commenced this action in the United States District Court for the Eastern District of Missouri, on behalf of herself and others similarly situated,

challenging the exclusion of such individuals from coverage under the State's medicaid plan. She contended, *inter alia*, that since she would have qualified for medical aid under the State's general relief program in the absence of the enactment of the supplemental security income program, the State was required to provide her with medical assistance under Title XIX.

The district court entered judgment for respondent (Pet. App. A7-A8). The court construed Section 1902(f) of the Act as permitting the State of Missouri "to exclude individuals from medical assistance coverage unless the State * * * would have been * * * required to provide medical assistance to such persons under Missouri's medical assistance plan in effect on January 1, 1972" (Pet. App. A5). The court found that "under Missouri's January 1, 1972, approved medical assistance plan, the [State was] required to provide medical assistance to all recipients of * * * General Relief" *(ibid.)*. Accordingly, the district court ordered petitioners "to provide medical assistance to those recipients of [supplemental security income] benefits in Missouri who meet the January 1, 1972 Missouri General Relief eligibility requirements * * * " (*id.* at A7-A8). The court of appeals affirmed (*id.* at A9-A10; see *id.* at A11).

DISCUSSION

The State of Missouri is not required by Title XIX of the Social Security Act to provide medical aid to respondent and the class she represents "unless [the] State * * * would have been * * * required to provide medical assistance to such individual[s] * * * had its plan for medical assistance approved under [Title XIX] and in effect on January 1, 1972, been in effect * * * ." Section 1902(f) of the Act. The courts below determined that this statutory provision did not permit the State to exclude respondents from medicaid coverage because in 1972 the State had provided medical aid to similarly situated individuals as part of its program of general relief. We do not believe that Congress intended this result.

This case turns, at least in part, on considerations of federalism. Under the lower courts' reading of Section 1902(f), because a state conducted its own state-financed medical aid program in the past, it now must provide medicaid to individuals whom it otherwise would be entitled to exclude from coverage. In other words, the courts below concluded that Congress, in amending Title XIX, differentiated between the states on the basis of whether they had conducted their own state-financed medical aid programs in 1972, and that it chose to impose a heavier burden on the states that had conducted such programs. But if Congress had intended to disadvantage states for having conducted, with their own monies, welfare programs more expansive than those the federal government had theretofore been willing to sponsor, surely that intention would have stimulated debate and controversy. The courts below point to no such debate, and we have found none.

In the absence of compelling legislative history to the contrary, it should be presumed that Congress was not concerned with the scope of state-financed relief programs and did not intend either to interfere with a state's ability to expand or contract such a program or to impose some special burden upon a state because of the operation of such a program in the past.[3] Congress can fairly be understood to have been concerned, in enacting Section 1902(f), only with the relationship of the new supplemental security income program to the existing federal-state medicaid programs.

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[3]The State of Missouri was entitled to receive, and presumably did receive, federal assistance to cover a portion of the purely administrative costs of operating its program of exclusively state-financed payments to general relief recipients. See Section 1903(a) (3) of the Act. But we are not aware of anything in the legislative history that indicates that Congress intended that such a limited federal nexus be the basis for imposing greater medicaid burdens upon the states.

Viewed from this perspective, Section 1902(f) can be seen as standing, at a minimum, for the proposition that the states are not required to expand the scope of their pre-1974 federally funded medicaid programs as a result of the enactment of the supplemental security income program. That proposition is fully consistent with the State's refusal to extend medicaid coverage to the respondent class. Moreover, as we now show, the language of Section 1902(f) conforms with this understanding of its purpose and meaning.

1. The decisions below rest upon the legal conclusion that, within the meaning of Section 1902(f), the State "would have been * * * required to provide medical assistance to" respondents under its 1972 medical plan (see Pet. App. A5). That conclusion was based upon a misunderstanding of the term "medical assistance."

As has been indicated, the medical aid provided to the respondent class under the 1972 plan was made available under a wholly state-financed general relief program; no federal funds were claimed or received by the State for payments made with respect to the respondent class (*ibid.*). But under the Act, "medical assistance" refers solely to medical aid that qualifies for federal matching funds. "[T]he Secretary * * * shall pay to each State which has a plan approved under this title * * * an amount equal to [a specified] percentage * * * of the total amount expended * * * *as medical assistance* under the State plan * * *." Section 1903(a)(1) of the Act, 42 U.S.C. (Supp. V) 1396b(a)(1) (emphasis added). See also Section 1902(a)(10) of the Act. In turn, "medical assistance" is defined as payments to certain individuals—the categorically or medically needy—for certain medical

services or needs. Section 1905 (a) of the Act.[4] Payments to other individuals, or for other medical services or needs, are not "medical assistance" and do not qualify for federal matching.

In other words, if payments qualify for federal reimbursement, they constitute "medical assistance"; otherwise, they do not. It is stipulated that in 1972 medical aid to the respondent class did not qualify for federal reimbursement. The necessary legal inference, therefore, is that that medical aid was not "medical assistance" as that term is used in the Act.[5] In short, the State would not "have been * * * required to provide *medical assistance* to" respondents under its 1972 plan. Accordingly, the State was entitled under Section 1902(f) to deny coverage to respondents under its current plan.

2. The courts below also misconstrued the term "required" in Section 1902(f). That term, properly understood, refers to requirements imposed by federal statute and not to requirements arising solely out of state law. The State was "required" to provide medical aid to the respondent class by its 1972 general relief program, a portion of which

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[4]Respondents by definition were not categorically needy under the 1972 plan, and they apparently do not allege that they are medically needy. Whether an individual is medically needy depends upon two factors: satisfaction of the physical requirements for categorical assistance, and satisfaction of the financial standard of medical need established by the state. See Sections 1902(a) (10)(C) and 1905(a) of the Act. The State of Missouri has not extended medicaid coverage to the medically needy and therefore has had no occasion to establish a standard of medical need.

[5]The parties have stipulated that "[u]nder the approved Missouri State Plan for Medical Assistance in effect on January 1, 1972, * * * recipients of General Relief, were eligible for Medical Assistance" (Add. Stip. 2). But in view of the accompanying stipulation that the assistance was made without federal reimbursement (*ibid.*), it is clear that the term "Medical Assistance" was used there in its general, nonstatutory sense *i.e.*, as synonymous with "medical aid."

had been incorporated into its federally approved medical aid plan. But federal law required the State to provide medical assistance only to the categorically needy, not to the respondent class, and it is the federal requirement with which Congress presumably was concerned.

a. The structure and purpose of Section 1902(f) support the conclusion that the word "required," as there used, means "required by federal statute." The statute provides that "[n]otwithstanding any other provision" of Title XIX, no state "shall be required" to provide medical assistance to an individual "unless such State * * * would have been * * * required to provide" such assistance under its 1972 plan. The word "required" is used twice. The first use obviously refers solely to a federal statutory requirement: no state "shall be required [by this Act] to provide medical assistance * * * ." It is logical in this context to construe the second use also as referring to federal statutory requirements: "unless [under this Act] such State * * * would have been * * * required to provide medical assistance * * * ."

As thus construed, Section 1902(f) granted the State of Missouri the option to choose not to extend medicaid coverage to individuals, such as respondents, who were not categorically needy under the State's 1972 standards. This construction is consistent with the legislative purpose underlying the enactment of Section 1902(f). Congress understood that establishment of the supplemental security income program would increase the number of individuals considered to be "categorically needy" and that a requirement that the states provide medical assistance to the individuals newly added to that class could be burdensome. See S. Rep. No. 93-553, *supra*, at 56. Section 1902(f), as we construe it, enables the states, as Congress intended, to avoid this burden if they choose to do so.

b. Respondents contend (Br. in Op. 12), however, that the second use of the term "required" in the statute must mean required by the terms of the state's 1972 plan, because it is followed by the qualifying clause, "had its plan for medical assistance approved under this title and in effect on January 1, 1972, been in effect * * *." Respondents argue that if Congress had intended to refer only to a federal requirement, it would have been unnecessary to mention the state's 1972 plans.

Mention of the states' 1972 plans was necessary, however, because in 1972 the states were empowered to establish the need levels that defined the class of categorically needy entitled to federally funded medical assistance. The federal statute required medicaid coverage for the categorically needy, and it defined, by reference principally to physical attributes, a class of individuals who could be treated as categorically needy; but it left to the states the task, *inter alia,* of setting the standards of need that would determine which members of that class actually would be treated as categorically needy. There was therefore no comprehensive federal definition of "categorically needy," only a partial definition.

The states completed the definition in part by setting need standards responsive to local conditions. Thus the only way for Congress to refer to the class of individuals to whom the states were required to furnish medical assistance under prior federal law was by reference to the class of individuals to whom the states had been required to make payments by virtue of the need standards set forth in their separate plans.

3. Fifteen states have elected to limit medicaid coverage in accordance with Section 1902(f).[6] We are informed that the medicaid plans of at least ten of these states covered more

[6]In addition to Missouri, the states are Colorado, Connecticut, Hawaii, Illinois, Indiana, Minnesota, Mississippi, Nebraska, New Hampshire, North Carolina, Ohio, Oklahoma, Utah, and Virginia.

than just the categorically needy in 1972.[7] It does not appear, however, that any of those states will be directly affected by the outcome of this litigation. The problem presented by this case arises only when a state denies medicaid coverage to a categorically needy individual who would have received some form of medical aid under the state's 1972 medicaid plan. To the best of our knowledge none of the other states that has exercised the election under Section 1902(f) currently denies coverage to such individuals. Moreover, we are not aware of any similar litigation involving any other state. In these circumstances, we cannot say that the case presents an issue of sufficiently general importance to warrant this Court's review.

CONCLUSION

The petition for a writ of certiorari should be denied.

Respectfully submitted.

DANIEL M. FRIEDMAN,
Acting Solicitor General.

FEBRUARY 1977.

[7]The considerations relevant to the scope of the medicaid obligations of the majority of those states, which covered both the categorically needy and the medically needy but not others, will be different from those we believe to be controlling here, for those states would have received federal matching funds with respect to the medical payments made to all individuals covered by their 1972 plans. However, a holding that the State of Missouri is compelled to provide medical assistance to all categorically needy individuals who would have received benefits under its 1972 plan would appear to apply to the other states as well.